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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LORRIE LEE ASPAAS** **aka LORRIE LEE CLARK** **aka LORRIE LEE GALLEGOS** 1092 Crimson Drive San Marcos, California 92069 Registered Nurse License No. 498118 Respondent.	Case No. 2009-58 **ACCUSATION**

Ruth Ann Terry, M.P.H., R.N. ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about March 31, 1994, the Board issued Registered Nurse License Number 498118, to Lorrie Lee Aspaas, also known as Lorrie Lee Clark and Lorrie Lee Gallegos ("Respondent"). The license will expire on April 30, 2010, unless renewed.

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JURISDICTION

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

5. Code section 2761(a) states, in pertinent part, that the Board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for unprofessional conduct.

6. Code section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(e) Falsify or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

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7. Code section 2725(b)(1) states, in pertinent part, that the practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients.

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(K).

10. "Phenergan" (Promethazine) is a dangerous drug within the meaning of Business and Professions Code section 4022 in that it requires a prescription under federal law.

SHARP GROSSMONT HOSPITAL

FIRST CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)

11. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct, as defined in Code section 2762(e), in that between August 6, 2004, and September 30, 2004, while employed as a registered nurse at Sharp Grossmont Hospital, located in La Mesa, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

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Patient 1:

a. On or about August 6, 2004, at 1650 hours, Respondent signed out a 25 mg. vial of Phenergan for administration without a physician's order. Respondent failed to chart the administration of the Phenergan or otherwise account for the disposition of the Phenergan in any hospital or patient record.

Patient 3:

b. On or about August 26, 2004, at 1542 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent failed to chart the administration of the Dilaudid or otherwise account for the disposition of the Dilaudid in any hospital or patient record.

c. On or about August 26, 2004, at 1650 hours, Respondent signed out a 25 mg. vial of Phenergan for administration. Respondent charted the administration of 12.5 mg. of Phenergan at 1654 hours, but failed to account for the disposition of the remaining 12.5 mg. of Phenergan in any hospital or patient record.

d. On or about August 26, 2004, at 1718 hours, Respondent signed out a 25 mg. vial of Phenergan for administration without a physician's order. Respondent failed to chart the administration of the Phenergan or otherwise account for the disposition of the Phenergan in any hospital or patient record.

Patient 4:

e. On or about August 29, 2004, at 1936 hours, Respondent signed out a 25 mg. vial of Phenergan for administration without a physician's order. Respondent failed to chart the administration of the Phenergan or otherwise account for the disposition of the Phenergan in any hospital or patient record.

Patient 6:

f. On or about August 23, 2004, at 1729 hours, Respondent signed out 4 mg. of Dilaudid for administration without a physician's order. Respondent charted wasting 3.5 mg. of Dilaudid at 1729 hours, but failed to account for the disposition of the remaining .5 mg. of Dilaudid in any hospital or patient record.

Patient 11:

g. On or about September 17, 2004, at 1249 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent failed to chart the administration of the Dilaudid or otherwise account for the disposition of the Dilaudid in any hospital or patient record.

Patient 12:

h. On or about September 26, 2004, at 1042 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted wasting 1 mg. of Dilaudid and documented the administration of 1 mg. of Dilaudid on the Pyxis. However, Respondent failed to chart the administration of the 1 mg. of Dilaudid on the medication administration record or in the nursing notes.

Patient 13:

i. On or about September 12, 2004, at 1451 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted the administration of 2 mg. of Dilaudid at 1517 hours.

Patient 15:

j. On or about September 16, 2004, at 0712 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted the administration of 2 mg. of Dilaudid at 0710 hours.

Patient 16:

k. On or about September 16, 2004, at 0911 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted the administration of 2 mg. of Dilaudid at 0900 hours.

Patient 17:

l. On or about September 17, 2004, at 1939 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted the administration of 2 mg. of Dilaudid at 2050 hours.

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Patient 18:

m. On or about September 17, 2004, at 0714 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted the administration of 2 mg. of Dilaudid at 0720 hours.

Patient 19:

n. On or about September 26, 2004, at 0733 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted the administration of 2 mg. of Dilaudid at 0730 hours.

Patient 20:

o. On or about September 28, 2004, at 0710 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent failed to chart the administration of the Dilaudid or otherwise account for the disposition of the Dilaudid in any hospital or patient record.

Patient 21:

p. On or about September 28, 2004, at 1106 hours, Respondent signed out 1 mg. of Dilaudid for administration without a physician's order. Respondent charted wasting 1 mg. of Dilaudid and the administration of 1 mg. of Dilaudid at 1109 hours.

Patient 22:

q. On or about September 28, 2004, at 1314 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted the administration of 2 mg. of Dilaudid at 1341 hours.

Patient 23:

r. On or about September 30, 2004, at 1408 hours, Respondent signed out 2 mg. of Dilaudid for administration. Respondent charted the administration of .5 mg. of Dilaudid at 1424 hours, and charted wasting 1 mg. Dilaudid at 1408 hours, but failed to account for the disposition of the remaining .5 mg. of Dilaudid.

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s. On or about September 30, 2004, at 1716 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted wasting 1.5 mg. of Dilaudid at 1752 hours, and charted the administration of .5 mg. at 1805 hours.

Patient 24:

t. On or about September 30, 2004, at 1032 hours, Respondent signed out 2 mg. of Dilaudid for administration without a physician's order. Respondent charted wasting 1 mg. of Dilaudid at 1032 hours, and charted the administration of 1 mg. of Dilaudid at 1034 hours.

TRI-CITY MEDICAL CENTER

SECOND CAUSE FOR DISCIPLINE

(Failure to Comply with Regulations)

12. Respondent is subject to discipline under Code section 2761(d), in that on or about April 18, 2007, while on duty as a registered nurse at Tri-City Medical Center, located in Oceanside, California, Respondent failed to ensure the safety and protection of a patient, as defined in Business and Professions Code section 2725(b)(1). Without permission, Respondent took a photograph of an emergency room patient's x-ray that was up for viewing on the electronic PACs System in the physicians work space, using her cellular phone. The x-ray contained the patient's identifiable information.

PRIOR DISCIPLINE

13. Effective April 11, 1999, pursuant to the Stipulation in Settlement and Decision, attached hereto as **Exhibit A**, in Accusation No. 97-130, attached hereto as **Exhibit B**, the Board of Registered Nursing revoked Respondent's Registered Nurse License No. 498118. However, the revocation was stayed and Respondent was placed on probation for a period of three (3) years with terms and conditions.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 498118, issued to Lorrie Lee Aspaas, also known as Lorrie Lee Clark and Lorrie Lee Gallegos;

2. Ordering Lorrie Lee Aspaas, also known as Lorrie Lee Clark and Lorrie Lee Gallegos to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such order and further action as deemed necessary and proper.

DATED: 9/16/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

Accusation (kdg) 7/17/08
SD2007802388